

# POPTech Tools Series

Annotated Bibliographies  
on  
Reproductive Health,  
Financial Sustainability, and  
Quality and Access

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## **About the POPTECH Tools Series**

POPTECH provides consulting support to USAID on design and evaluation of USAID-funded population and reproductive health projects. The POPTECH Tools Series comprises several analytic “tools” designed to support and enhance the expertise of POPTECH consultants, promote consistency and quality across reports, and provide assistance to the Global Bureau and Mission staff. These tools include checklists and papers that focus on issues central to the design and evaluation of family planning and reproductive health projects.

Included in the Series are three annotated bibliographies on Reproductive Health, Quality and Access, and Financial Sustainability. The Annotated Bibliography on Reproductive Health, compiled by both Charlotte Colvin and Laurie Schwartz, includes resources on Safe Motherhood, Postabortion Care, Adolescent Reproductive Health, Sexually Transmitted Diseases, HIV/AIDS, Breastfeeding, and Nutrition. The Annotated Bibliography on Financial Sustainability was compiled by Laurie Schwartz. Charlotte Colvin compiled the Annotated Bibliography on Quality and Access.

To compile this list of resources, POPTECH queried experts in the field for the most important publications in each subject area over the last ten years. Please contact POPTECH at (703) 522-5540 or [poptech@bhm.com](mailto:poptech@bhm.com) for further information.

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# **Annotated Bibliography on Reproductive Health**

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## Safe Motherhood

**Family Health International. “Reproductive Health After Pregnancy.” *Network*. vol. 17, no. 4. Research Triangle Park, NC: Family Health International. Summer 1997.**

This series of articles focuses primarily on postpartum care with several articles focused on postabortion family planning services. FHI is a strong advocate of postpartum and postabortion family planning counseling, and suggests a number of ways to integrate such activities into existing services based on field research and case studies. The authors have included information on the appropriate time to introduce specific methods following childbirth, quality of care standards, strategies for providing emergency postpartum care, male involvement in postpartum and postabortion family planning counseling, and protocols for postabortion family planning counseling for women. The articles include extensive data from case studies and identify successful programs in each topical area.

**Heichelheim, J. and Koblinsky, M., eds. “Learning and Action in the First Decade - The MotherCare Experience.” *MotherCare Matters*. vol. 6, no. 4. Arlington, VA: John Snow, Inc. October 1997.**

This document is a special edition of the quarterly *MotherCare Matters* newsletter focusing on the lessons learned throughout ten years of the MotherCare project. First, the special edition describes the Pathway to Survival, a framework for decision-making in the context of maternal child health. The framework includes four elements that lead to increased chances for survival for mothers: Recognition of Problems, Decision-Making Regarding Care, Access to Quality Care, and Quality of Care upon reaching a point of entry into the health system. Project research has resulted in the following targets for interventions to support the framework: clinical quality of care, behavior change, and policy formulation. MotherCare has explored these interventions in a number of demonstration and operations research projects, and this issue of the newsletter describes three of the demonstration and two of the operations research projects. They are located in Bolivia, Guatemala, Indonesia, Ghana, and Uganda. In addition to training midwives to perform specific actions related to care of mothers during labor, the studies include research on anemia and STD treatment for maternal and infant health.

**Lettenmaier, C., Liskin, L., Church, C., and Harris, J. “Mother’s Lives Matter: Maternal Health in the Community.” *Population Reports*. Series L, no. 7. Baltimore: Johns Hopkins School of Public Health, Population Information Program. September 1988.**

Although it is not the most current publication on maternal care, this report from the Johns Hopkins University Center for Communications Programs provides a thorough description of typical problems involved with prenatal care, labor and delivery, and postpartum care. The report discusses not only the specific complications that can occur

at each of these stages, but also provides a social context for pregnancy and childbearing. The authors argue that safe motherhood is not just a matter of safe pregnancy, but that a woman's lifetime experiences greatly affect her ability to safely bear a child. For example, they focus on good nutrition throughout a woman's life as a key factor contributing to her well-being as a pregnant or lactating woman.

Additionally, the report covers the training of community health workers, noting successes and failures with expanding the role of traditional birth attendants in women's health. They provide numerous examples of problems and solutions that can serve as a model for future training programs. Overall, this publication is useful for consultants looking for basic information on maternal care and helpful suggestions for evaluating training programs for obstetrical care providers at the community level.

**Li, X. F., Fortney, J. A., Kotelchuck, M., and Glover, L. H. "The Post Partum Period: The Key To Maternal Mortality." *International Journal of Gynecology and Obstetrics*. Supplement 54, pp. 1-10. 1996.**

This article begins with the recognition that most research on maternal care focuses on the prenatal period, while more than 80% of maternal deaths occur within one week after delivery. The authors question the emphasis on prenatal care as a preventive measure and argue that postpartum care should receive more attention than is currently the norm. The document includes data from existing studies on maternal mortality to compare postpartum maternal mortality in developing countries to rates in the United States.

After presenting the data on maternal mortality rates, the authors disaggregate the number of maternal deaths by time period within the postpartum interval. The first 24 hours is the most critical for providing postpartum care to mothers, with 44.9% of all maternal deaths occurring during this time. The article continues with suggestions for interventions to prevent such deaths. The interventions are classified as primary interventions, early detection and secondary interventions for postpartum complications. Each category of intervention is described with the appropriate level of care listed for each including how the interventions can be incorporated safely within the various tiers of a national health system.

**Maine, D. *Safe Motherhood Programs: Options and Issues*. New York: Center for Population and Family Health, Columbia University. 1991.**

This document deals with the causes of maternal death and efforts to prevent maternal mortality. The author explains the various measures of maternal mortality and presents an analytical model of its causes. This model demonstrates the relationship between social, cultural, and economic factors and health behavior, health status, access to health services and other unknown factors which have a direct effect on pregnancy outcomes. Maine then reviews options for improving maternal care and priorities for future strategies.

First, she discusses the high value of providing safe, legal abortion services, noting that this action would greatly reduce the maternal mortality ratio. Second, she details current prenatal care programs and notes that they have not always been successful at preventing complications with their limited focus on screening. She then discusses

training traditional birth attendants to develop their skills to better manage difficult deliveries. Finally, she reviews the strategy of informing and mobilizing the community on the issues of safe motherhood. For each program strategy, she presents data on interventions to identify advantages and disadvantages.

The concluding section of this publication recommends three priorities for future safe motherhood strategies. Programs must ensure that mothers have access to emergency obstetrical care. They must also help women reduce their exposure to the risks of unwanted pregnancy by providing family planning services and safe, legal abortion. Lastly, they must establish and improve other maternal health services such as maternity waiting homes.

**McDonagh, M. "Is Antenatal Care Effective In Reducing Maternal Morbidity And Mortality?" *Health Policy and Planning*. Oxford: Oxford University Press. vol. 11, no. 1. pp. 1-15. 1996.**

McDonagh questions the assumptions underlying antenatal care by revealing the lack of rigorous evaluation of specific interventions in this challenging article. She argues that there is not enough research to prove that existing interventions actually reduce maternal mortality and morbidity and points out that randomized controlled trials to test antenatal care are necessary to learn more about what is successful. She focuses on the outcomes of antenatal care for mothers and the appropriateness of technical services delivered rather than on other analyses such as cost effectiveness. The interventions that are evaluated are: weight monitoring, blood pressure screening, and abdominal examination.

McDonagh finds that these routine screenings do not contribute to a mother's understanding of how she can better care for herself during pregnancy. For example, weight monitoring itself does not address the possible infection or excessive work load that could be contributing to a lower than average pregnancy weight. Additionally, many women do not seek antenatal services often enough to track weight changes over time. Even if a woman does engage in routine weighing throughout her pregnancy, weight-related risks do not always indicate that a woman will have an abnormal pregnancy or delivery. The author notes that the concept of antenatal care is quite difficult to study because the care itself is so variable, and while standards may be encouraged, they are certainly not always followed. She concludes by stating that only interventions such as improvement in women's education and promotion of reproductive health can change the context in which antenatal care is delivered and thus, the effectiveness of the care given.

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## **Postabortion Care**

**AVSC International. *COPE Supplementary Self Assessment Guide for Postabortion Care*. Draft. 1997.**

This publication, in draft form as of July 1998, is a comprehensive checklist of questions that can be used by evaluation specialists to determine the quality of postabortion care in individual clinics. The questions are organized by categories reflecting the patients' rights as described in AVSC's COPE (Client Oriented, Provider Efficient) manual.

These include Patients' Rights to Information; Access; Good Client-Provider Interaction and Counseling; Informed Choice, Opinion and Confidentiality; Safety; Privacy, Dignity and Comfort; and Continuity. The assessment also includes questions grouped according to Staff Needs: Good Management and Supervision; Training Updates and Orientations; and Supplies and Site Infrastructure. The final section of this document is an appendix listing the minimum supplies and equipment necessary for a Manual Vacuum Aspiration (MVA) procedure. The PAC assessment should be complemented by the COPE assessment for Infection Prevention, also available from AVSC International.

**Benson, J., Gringle, R., and Winkler, J. "Preventing Unwanted Pregnancy: Management Strategies to Improve Postabortion Care." *Advances in Abortion Care*. vol. 5, no. 1. Carrboro, NC: IPAS. 1996.**

Common management problems associated with postabortion care are the focus of this document written by three well-known experts in the field. Specifically, the authors detail issues such as provider attitudes toward clients, and they emphasize the importance of postabortion family planning counseling. They discuss the introduction of such counseling into existing abortion care services and the challenges of sustaining family planning counseling in settings where clinicians may be resistant to providing the service. Benson, Gringle, and Winkler argue that family planning counseling be fully integrated with postabortion care services and that clinic staff view this activity as essential, not additional or optional. They then turn to aspects of quality of care that range from clinical concerns to cost, offering practical approaches to deal with a number of important issues.

**Huntington, Dale. *Advances and Challenges in Postabortion Care Operations Research*. New York: Population Council. 1998.**

This summary report documents the principle themes and key points drawn from papers presented at a global meeting on postabortion care operations research. The purpose of the meeting, held at the Population Council's New York office in January 1998, was to: (1) review progress in the development of operations research methodologies pertaining to postabortion care; (2) identify elements in the design of new postabortion care services; and (3) suggest future areas for postabortion care operations research. The document is divided into eight sections which define issues surrounding postabortion care; discuss intervention design and implementation; examine quality of indicators and measurement techniques; consider follow-up and cost studies; address decentralization and scaling-up of postabortion care services; acknowledge ethical dimensions and point to future topics for postabortion care operations research. A summary of each section is provided with discussant overviews and recommendations.

**Kinoti, S. N., Gaffikin, L., Benson, J., and Nicholson, L. A. *Monograph on Complications of Unsafe Abortion in Africa*. Arusha, Tanzania: Commonwealth Regional Health Community Secretariat. 1994.**

This publication is the result of a collaboration among the Commonwealth Regional Health Community Services (CRHCS), IPAS, and JHPIEGO. The authors have summarized the results of a comprehensive literature review and data collection on abortion in three countries: Zambia, Uganda, and Malawi. The final product of the literature review is an annotated bibliography that includes published material and “grey” literature, and the data collection is organized according to findings on mortality and morbidity, cost issues, and provider/patient perspectives as they relate to unsafe abortion.

Specifically, the mortality/morbidity findings focus on hemorrhage and sepsis as the major complications of unsafe abortion and look at the magnitude of each problem. The cost issues center on the use of manual vacuum aspiration (MVA) as a cheaper and safer alternative to sharp curettage. The annotated bibliographies include papers on the following topics: Magnitude of Unsafe Abortion, Clinical Issues, Cost Issues, Contraception and Abortion, Male Perspectives, and Abortion Laws.

**Leonard, A. and Winkler, J. “A Quality of Care Framework for Abortion Care.” *Advances in Abortion Care*. vol. 1, no. 1. Carrboro, NC: IPAS. 1991**

Leonard and Winkler use the Quality of Care framework developed by Judith Bruce to suggest an appropriate design for abortion services. The design is intended to help identify strengths and weaknesses of abortion care services. The authors include strategies for improvement and present them as checklists under the categories of Appropriate Abortion Care Technology; Technical Competence; Interactions Between Women and Providers; Information and Counseling; Postabortion Family Planning and Reproductive Health Care; Equipment, Supplies, and Medications; and Access to Care. The article covers abortion care technology; technical competence of service providers; interactions between providers and clients; information and counseling; postabortion family planning and reproductive health; and equipment, supplies, and medication. The checklists provide standards for each element of care.

**Salter, C., Johnston, H. B., and Hengen, N. “Care for Postabortion Complications: Saving Women’s Lives.” *Population Reports*, Series L, no. 10. Baltimore, Johns Hopkins School of Public Health, Population Information Program. September 1997.**

This document is a comprehensive report on postabortion care (PAC) programs. In addition to the numerous statistics and figures used to illustrate the magnitude of the problem, the authors have documented lessons learned from existing PAC programs and outlined the key elements that should be included in any PAC services. They also detail the specific complications associated with unsafe abortion that are likely to cause death or disease. Unlike similar documents that focus on the elements of care in terms of emergency obstetrical care, family planning counseling, and links to reproductive health care, this report also focuses on accessibility and decentralization of services. Salter, Johnson, and Hengen outline the appropriate services to be provided at each facility in

the health care system. Specifically, they identify the resources needed for proper procedures in abortion using the manual vacuum aspiration, complete with information on pain management. They note that one key to the development of successful PAC services is that providers are motivated and prepared to conduct postabortion family planning counseling as well as make links between postabortion clients and other reproductive health, especially since PAC is often provided in crisis situations.

**Settergren, S. *What CAN you do? Postabortion Care in East and Southern Africa.* Washington DC: POLICY Project, The Futures Group International in collaboration with Research Triangle Institute and the Centre for Development and Population Activities. 1997.**

This informative brochure was produced by the Postabortion Care Working Group for East and Southern Africa, a working group of professionals concerned about the development of postabortion care (PAC) services in this region. The document provides a brief description of the problem of unsafe abortion in the ESA region and then identifies USAID guidelines for PAC. The key interventions allowed under current funding restrictions are listed, as well as a graphic presentation of a results framework demonstrating the linkages between PAC services and USAID's strategic objectives. A comprehensive bibliography on PAC and contact information for the members of the working group is also included.

The brochure outlines three essential elements of PAC services: emergency obstetrical care, family planning counseling, and links to other reproductive health services. Operations research projects that are integrating these elements into existing services are briefly described, as well as recent efforts to improve information, education, and communication programs on PAC. The authors present powerful arguments for supporting comprehensive PAC as the best way to curb unsafe abortion in this region. It is a useful document in that it is a substantial source of information on the extent of the problem and effective approaches to developing PAC services.

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## **Adolescents**

**Alan Guttmacher Institute. *Into A New World: Young Women's Sexual and Reproductive Lives.* New York, NY: Alan Guttmacher Institute. 1998.**

This informative piece describes the conditions of young women's lives and includes comparative data from developed and developing countries, presented throughout the report in numerous graphs, charts, and tables. The document focuses on the needs of young people in a rapidly changing world that is quite different from the world in which their parents and elders were raised. For example, the higher education requirements of today's workforce are difficult for the world's one billion adolescents, especially girls, to attain. Those girls that reach these higher education goals marry and have their first birth later than their counterparts who are unable to stay in school. The report covers such topics as contraceptive use, reproductive health risks, sexually transmitted disease,

maternal/child health for young women and their children, and urbanization. This publication also highlights the need for further research in the area of adolescent health. While there are many studies of young women, the needs and behavior of young men are often not considered. Additionally, there is a dearth of information on adolescents under the age of fifteen. Therefore, these areas of adolescent health merit special attention in future research.

**Hughes, J. and McCauley, A. “Improving the Fit: Adolescents’ Needs and Future Programs for Sexual and Reproductive Health in Developing Countries.” *Studies in Family Planning*. vol. 29, no. 7144. 1998.**

Hughes and McCauley open this article with the disclaimer that programming efforts are but one of many influences that contribute to adolescent sexual and reproductive health. They focus on primary prevention and care efforts and emphasize that lack of information is one of the greatest barriers to adolescents’ well-being. Parents and health workers are often unprepared to answer questions from young people about sexual and reproductive health matters. The article continues with information on behavioral theories that guide interventions and the types of resources that are available to those who wish to provide services. The authors categorize the types of youth that should be reached by various program efforts and describe six guiding principles for reaching each group. Currently, there are a number of small programs, such as demonstration projects, that do not have links with large scale programs. Furthermore, the existing programs have not been evaluated nor has research been conducted to try and determine the most effective ways to approach adolescent reproductive health. The authors suggest that further research and evaluation is needed in this area to ensure that appropriate interventions are developed under the six principles illustrated in the article.

**Jejeebhoy, Shireen. “Adolescent Sexual and Reproductive Behavior: A Review of the Evidence from India.” *Social Science and Medicine*. vol. 46, no. 10. 1998.**

Jejeebhoy’s work documents the existing research on adolescent sexual and reproductive behavior in India, noting the inherent difficulty in exploring this issue in the Indian context. She discusses the need for behavioral research on this subject and notes survey problems that resulted in biased data for the studies included in the article. Currently, there is a need for information on adolescent sexuality, reproductive morbidity, abortion, and reproductive health decision-making in India. Additionally, researchers should include analysis of social and cultural factors in each of these areas to design more effective interventions.

Adolescents comprise almost a quarter of the population in India. The transition from youth to adult in this country varies widely, with adolescents in the North facing far greater challenges than their counterparts in the South. The studies included in the article describe marriage patterns, onset of sexual activity, knowledge of contraceptives and reproductive health, attitudes toward sex and marriage, and decisions regarding sexual and reproductive health. Jejeebhoy finds few examples of reproductive health services that are geared toward adolescents and concludes the piece with suggestions for future research and program directions.

**Key Elements of Young Adult Reproductive Health Programs: Health Facility, Outreach, School-based, and Social Marketing/Mass Media Approaches. FOCUS on Young Adults Project. 1997. (Can be downloaded from <[www.pathfind.org/focus.htm](http://www.pathfind.org/focus.htm)>).**

The USAID-funded FOCUS on Young Adults Project has produced a series that summarize the knowledge and lessons learned to date about four models of providing young adult reproductive health programming and services: health facility, school-based, outreach, and social marketing/mass media. Based on the findings of a consensus panel of young adult reproductive health (YARH) experts and a comprehensive literature review, each paper documents existing YARH programs and successful key elements that merit consideration, and identifies future research needs. This series is useful to program evaluation and design experts who are looking for examples of models that work—and the major questions for which gathering empirical data will improve understanding of what works—in the field of YARH programming.

**Population Reference Bureau International Programs. *Adolescent Women in Sub-Saharan Africa: A Chartbook on Marriage and Childbearing*. Washington, DC: Population Reference Bureau. 1992.**

This resource on marriage and childbearing data for adolescent women in sub-Saharan Africa is introduced with a reiteration that investments in education are key for women's development, but early pregnancy and childbearing interfere with a young woman's ability to continue her schooling and reap the social and economic benefits. The chartbook addresses the issues of adolescent sexual experience, contraceptive use, and childbearing, with data from 11 countries that have participated in the Demographic and Health Surveys from 1986 through 1990. It includes information on marital status, unintended pregnancies, and disaggregates childbearing information by age. Additionally, the document provides figures for contraceptive use and knowledge, infant mortality rates among adolescents, and unmet need for family planning. The concluding section describes the policy implications of the information.

**Singh, S. "Adolescent Childbearing in Developing Countries: A Global Review." *Studies in Family Planning*. vol. 29, no. 7144. 1998.**

This article provides readers with a detailed review of current trends in adolescent childbearing with information on the variables of level of education and residence. After compiling figures on childbearing for adolescents in 43 countries, Singh examines whether adolescent pregnancies are wanted, mistimed, or unwanted and then calculates abortion rates among adolescents. In the section on abortion, she notes that adolescents are more likely than other women of reproductive age to suffer from the complications of sepsis, the most severe problem associated with unsafe abortion. Following the presentation of data, the author discusses implications for programs that target this issue. Overall, Singh finds that adolescent childbearing is declining in some areas, albeit slowly. She also notes that adolescent pregnancy is seen as more of a problem now than it was twenty years ago; thus, even in countries where the rate has fallen drastically, it is

considered an urgent public health concern. Singh postulates that greater awareness about the individual and societal consequences have led to this emphasis on adolescent childbearing as an important health problem. The author clearly demonstrates the link between higher levels of education and lower levels of teenage pregnancy in her presentation of the numbers. Specifically, in the countries for which data are available, the proportion of young women giving birth under age 20 has declined as they have access to higher education. This effect is quite noticeable in Kenya, Botswana, Tanzania, and Egypt.

**Yinger, N., de Sherbinin, A., Ochoa, L., Morris, L. and Hirsch, J. *Adolescent Sexual Activity and Childbearing in Latin America and the Caribbean: Risks and Consequences*. Washington, DC: Population Reference Bureau. 1992.**

This publication reviews survey data from the Demographic and Health Surveys for Latin America and two Centers for Disease Control (CDC)-assisted young adult reproductive health surveys to examine the risks and consequences of early sexual activity and childbearing for selected countries in Latin America and the Caribbean. The authors provide an overview of outcomes associated with early childbearing, including health outcomes for young mothers and their children, the risks of sexually transmitted infections for both young men and women, and costs to society of early childbearing. The authors suggest practical policy options, guided by the data presented in the report. Specifically, they promote educational policy aimed at keeping young women in school, recreational and vocational programs that encourage skills-building, sexuality education, access to family planning information, and IEC activities that target society as a whole to inform as many interested parties as possible about the risks and consequences of early pregnancy. The key to successfully reducing these risks appears to be educating girls and providing family planning services. In addition to descriptions of outcomes and policy options, the report contains numerous charts and graphs and several comparison studies that focus on specific determinants of adolescent sexual activity and early pregnancy.

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## **Sexually Transmitted Diseases**

**AIDSCAP. *Control of Sexually Transmitted Diseases: A Handbook for the Design and Management of Programs*. Arlington, VA: Family Health International. October 1997.**

This handbook describes innovative approaches to the diagnosis and treatment of sexually transmitted diseases in low-resource settings. In addition to relatively new approaches such as syndromic management, the handbook includes approaches that are “borrowed” from other fields. A number of country-specific examples are cited to demonstrate the success and failure of the demonstration projects that incorporate these approaches. The book recognizes the role of the informal health sector and reviews barriers to access to treatment. The authors note the importance of initial visits for STD

treatment and how to manage these experiences in such a way that will encourage return visits and follow up treatment.

The document describes approaches to treatment by individual risk group, and categorizes the core STD clients under the following headings: commercial sex workers, migrants, and youth. These three groups transmit the bulk of STDs and AIDSCAP has conducted a number of research projects to identify the most appropriate manner in which to target these groups. The authors present data from research to show the key elements of program design for each core group. The handbook concludes with chapters on STD services for women and self-medication for treatment which focus on the unique challenge of these two situations.

**Baker, Ndugga Maggwa, and Askew, Ian. *Integrating STI/HIV Management Strategies into Existing MCH/FP Programs. Lessons Learned from Case Studies in East and Southern Africa*. Nairobi, Kenya: Operations Research Technical Assistance II, The Population Council. July 1997.**

This report synthesizes findings from four case studies of programs that have developed and implemented an integrated STI/HIV management approach in an MCH/FP program. The report provides empirical evidence for policymakers, program managers, donors, and technical assistance organizations on how an integrated approach has been implemented in various programmatic, organizational, and sociocultural contexts. The synthesis in this document reveals that there are common components amongst all four integration programs (despite their independently implemented strategies) from which the authors have created a prototype model for integrating these services in a program. The authors discuss the advantages and disadvantages of these individual approaches. Additionally, they provide general recommendations for strengthening the implementation of integrated programs and offer suggestions for further operations research which would clarify remaining unknown issues.

**DeLay, P. "Adding STD Services Needs Careful Evaluation." *Network*. vol. 14, no. 4. Research Triangle Park, NC: Family Health International. 1994.**

In this brief article on the integration of STD services with family planning programs, DeLay discusses the problems associated with existing programs and explains why this strategy is frequently ineffective in reducing transmission of STDs at the community level. He notes that the women who attend family planning clinics are not usually considered "core transmitters" who will spread infections throughout the community. A core transmitter is an individual who has had two episodes of an STD in the past year and two new sexual partners within the last four weeks. Family planning clients tend to be at the end of the line of transmission, usually having contracted an infection from their partners. While DeLay encourages the use of primary prevention activities, such as IEC, at every possible level, such services as diagnosis of STDs are costly for family planning clinics. Syndromic management is often ineffective because many women are asymptomatic. Finally, he points out that there are no existing indicators that can be used to evaluate the success or failure of integrating STD services, thus monitoring these activities is very difficult.

**Dixon-Mueller, Ruth and Wasserheit, Judith. *The Culture of Silence: Reproductive Tract Infections Among Women in the Third World*. New York, NY: International Women's Health Coalition. 1991.**

In this key publication on reproductive health, Dixon-Mueller and Wasserheit challenge assumptions about the causes, diagnoses, and treatment of reproductive tract infections (RTIs) among women in the developing world. The document brings together published data on the incidence of RTIs in Africa, Latin America, and Asia, showing that RTIs are indeed a serious health problem for women, men and children. Contributing to treatment problems is the low priority given to recognizing RTIs as such an important issue for the health of those who inhabit these regions.

This publication describes the full range of problems associated with RTIs, as well as a description of the causes, symptoms, and treatment for specific infections. Harmful practices, such as female genital mutilation, are reviewed as they are connected to the problem of RTIs in the developing world. The authors summarize the consequences of these infections, including spontaneous abortion and unsafe delivery of newborns. Lastly, they link the causes of RTIs to the social position of women and suggest strategies for overcoming the “culture of silence” that surrounds RTIs.

**Elias, C. and Leonard, A. “Family Planning and Sexually Transmitted Diseases: The Need to Enhance Contraceptive Choice.” *Current Issues in Family Planning*. New York: The Population Council. 1: 191-199.**

This article examines the need for integration of family planning and STD services and a wider range of contraceptive methods to enhance couples' ability to protect themselves from STDs. The authors have outlined the challenges associated with STD prevention and contraceptive services. On the one hand, integrating STD services is rather practical, given that many of the same clinical and counseling skills are necessary to provide both family planning and STD services. However, the reality is that such efforts have not been successful for a number of reasons. In many cases, the focus on demographic goals as opposed to reproductive health has resulted in little policy-level support. Additionally, while there may be a skills overlap, the clinical orientation for STD services is quite different from that of a clinic providing only family planning services. Family planning is considered a preventive service, where STD treatment is viewed as curative.

Elias and Leonard address the technological, logistical, and social barriers to expanding family planning services to include STD diagnosis and treatment. The best methods of contraception do not protect couples from STDs and in some cases, may increase the risk of transmission. Likewise, the best methods for STD prevention are the least effective contraceptives, usually because of issues of incorrect use. Dual method use is difficult to promote in many developing country settings, and problems of method supply compound the issue. The authors note that male involvement is a key issue in a woman's ability or inability to use appropriate contraceptives to prevent STDs. The article concludes with a discussion of what can be expected due to technological advances in contraceptives.

**Tsui, A. O., Wasserheit, J. N., and Haaga, J. G., eds. *Reproductive Health in Developing Countries: Expanding Dimensions, Building Solutions*. Washington, DC: National Academy Press. 1997.**

This volume includes chapters on Healthy Sexuality; Infection-Free Sex and Reproduction; Healthy Pregnancy and Childbearing; Program Design and Implementation; and Costs, Financing, and Setting Priorities. While all of the topics are relevant to the design and evaluation of population and health programs, Chapter Three, "Infection-Free Sex and Reproduction," is a particularly comprehensive review of the issues surrounding sexually transmitted infections. The chapter covers the full range of topics associated with such infections, from the acute, chronic, and pregnancy-related complications of STIs to the physiological, personal, behavioral, and sociocultural environments that facilitate their spread. Additionally, the chapter describes the full range of consequences of STIs, from infertility to pregnancy related outcomes. The authors include information on the difficulty of measuring and appropriately treating STIs in low-resource settings and examine the strengths and limitations of interventions for prevention and treatment. They compare the epidemiology of STIs in developed countries to the vastly different profile of developing countries, as well as the various types of interventions appropriate for such widely dissimilar settings. The chapter concludes with a description of the types of interventions that can be offered and recommendations and research priorities for the future.

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## **HIV/AIDS**

**AIDS Control and Prevention Project (AIDSCAP). *Application of a Behavioral Surveillance Survey Tool*. Arlington, VA: Family Health International. October 1997.**

Serologic sentinel surveillance is often not possible in low-resource settings, nor is it always desirable. Behavioral Surveillance Surveys (BSS) provide significant information in the absence of necessary resources to conduct diagnostics with the objective of tracking known risk behaviors over time. This monograph describes the process of conducting a BSS in Bangkok, Thailand and how the methodology has been used to evaluate comprehensive HIV/AIDS/STD prevention programming. The best application/use of this tool is to measure the combined effect of two or more projects on behavior in the target population.

Included in this module are data from the initial two years of BSS. The authors' methodology is based on repeated cross-sectional surveys of population subgroups currently or potentially at risk for HIV or other STIs. The methodology section includes discussions on site selection for data collection, follow-up survey rounds (including summary table comparing advantages and disadvantages of fixed-site versus random selection), and questionnaire development (combining quantitative and qualitative formative research). Key sections of the Bangkok questionnaire and data analysis techniques are included in the appendices.

**AIDS Control and Prevention Project (AIDSCAP). *HIV Risk Behavioral Surveillance Surveys (BSS): Methodology and Issues in Monitoring HIV Risk Behaviors.* Summary from Workshop "HIV Risk Behavioral Surveillance: Country Examples, Lessons Learned, and Recommendations for the Future," held in Bangkok, Thailand, August 11-14, 1997. Arlington, VA: Family Health International. August 1997.**

This follow-on document to the AIDSCAP Evaluation Tool Module 4 further refines and develops the concepts and methodologies covered in the Behavioral Surveillance Surveys monograph. As a workshop summary document, the strength of this tool lies in the "experience sharing" of ten different BSS projects implemented in eight countries in Asia and Africa.

The goal of the workshop was to improve the methodology of behavioral surveillance (BS) by: 1) synthesizing the experience of researchers who have conducted BS in their respective countries; 2) resolving methodological issues and problems in conducting BS; and 3) documenting lessons learned in BS design, implementation, and dissemination of findings. Summaries and recommendations are provided for the following topics: the linkage of epidemiological and behavioral surveillance; planning for behavioral surveillance; BSS as an evaluation tool; choosing sentinel groups; sampling issues; indicators and questionnaire design; trend and other analysis issues; validity and reliability of the BSS; and dissemination of BSS results. Finally, the annex focuses on a technical discussion of parameters for sample sizes and weighting data.

**Buunk, Bram P., Bakker, A., Siero, F., van den Eijnden, R., and Yzer, M. Predictors of AIDS-Preventive Behavioral Intentions Among Adult Heterosexuals at Risk for HIV Infection: Extending Current Models and Measures. The Guilford Press. *AIDS Education and Prevention*, 10(2), 149-172m. 1998.**

Research has revealed that an individual's intention to use a condom is most often affected by his/her perceived barriers to condom use. This finding is derived from a study that examines predictors of the intention to consistently use condoms with sexual partners among adult heterosexual females and males, both married and single. The authors of the study chose variables drawn from the health belief model (Janz and Becker, 1984; Rosenstock, 1974), which was developed to understand why so many people do not take precautionary measures to prevent illness. Other theories upon which variables were chosen include the protection motivation theory (Rogers, 1983, 1984) and the theory of anticipated regret (Janis and Mann, 1977; Richard, 1994). In addition, the research in this study also examines the role of three types of normative influence: injunctive norms and descriptive norms as perceived in the reference group (a sample of 711 heterosexual adult females and males), as well as injunctive norms as perceived in potential new partners.

An outline of the study methodology, a description of the study sample and a discussion of the instrumentation developed and measures used by the researchers are provided. For those adept with statistical analyses, correlations between predictors and intention to use condoms and regression of intention to use condoms on a subset of predictors are critically examined, complete with tables of both correlation and regression

statistics. The conclusion section includes recommendations for consideration when designing interventions that are optimally effective among men and women.

**Royce, Rachel, Sena, A., Cates, W., and Cohen, M. "Sexual Transmission of HIV." *The New England Journal of Medicine*. April 10, 1997.**

This article focuses on the epidemiology and biology of the host-related factors of the classic epidemiological triangle that affect the sexual transmission of HIV. The primary focus is the author's exploration of host susceptibility and infectiousness: How can hosts lack susceptibility to HIV infection? How strong is the infectiousness of a host with late-stage infection and/or at the time of primary infection?

A comprehensive analysis of other factors and situations contributing to host susceptibility and infectiousness is built on the results of other research activities in the field of HIV/AIDS. Specific topics include: the influence of antiretroviral therapy on HIV infection; the implications of ongoing reproductive tract infections (strongly associated with susceptibility to HIV); the situations of cervical ectopy and male circumcision (the latter consistently shows a protective effect against HIV infection); the method of contraception used and whether or not a potential host is menstruating or is pregnant. The authors then review the strategies to date for preventing sexually transmitted HIV infection. Finally, they recommend that a combination of preventive strategies be used rather than a single approach.

**Gilson, Lucy, Mkanje, R., Grosskurth, H., Mosha, F., Picard, J., Gavyole, A., Todd, J., Mayaud, P., Swai, R., Fransen, L., Mabey, D., Mills, A., Hayes R. "Cost-effectiveness of Improved Treatment Services for Sexually Transmitted Diseases in Preventing HIV-1 Infection in Mwanza Region, Tanzania." *The Lancet*. vol. 350, December 20/27, 1997.**

Prior observational studies suggested that the sexual transmission of HIV might be increased in the presence of other STDs. WHO, the World Bank, and the European Union advocated the improved management of STDs as an effective, and potentially cost-effective strategy to control HIV long before supporting research emerged.

In the Mwanza Region of Tanzania, STD treatment services reduced the infection incidence rates of HIV-1 by 40% as evaluated in a community-randomized trial to measure the impact of improved STD treatment services on HIV-1 incidence. Researchers followed a cohort of adults 15-24 years for two years to empirically measure the cost-effectiveness of an HIV prevention strategy within the general population. The total and incremental costs of the intervention were estimated and used to calculate the total cost per case treated, the incremental cost per HIV-1 infection averted, and the incremental cost per disability-adjusted life-year (DALY) saved. The report also provides a thorough discussion examining potential sources of error inherent in costing studies is also provided.

**Calderon, M. Ricardo, ed. *STD Syndromic Management*. FHI/AIDS Prevention and Control Series. Latin America and the Caribbean Regional Office of the AIDS Control and Prevention (AIDSCAP) Project. Arlington, VA: Family Health International. November 1997.**

As part of the HIV/AIDS Prevention and Control SYNOPSIS Series, this booklet argues the importance of syndromic management of STDs through a holographic approach. Any one of the sections (holograms) contained in the booklet will provide the reader with an understanding of the whole subject matter. STD syndromic management is based on identifying a syndrome, a group of symptoms and easily recognized clinical signs associated with a number of well-defined etiologies. Treatment is generally determined without the aid of a laboratory test, making this approach particularly useful in low-resource settings.

The introduction summarizes the role of STDs in public health, including the HIV and STD global burden, and the linkage of STDs to HIV transmission. An outline on the theoretical foundation of STD syndromic management is provided and advantages/disadvantages and cost-effectiveness of this model are discussed. The authors demonstrate how to design STD flowcharts and how to measure the validity of a flowchart in terms of sensitivity and specificity. This booklet also includes highlights from the Introduction of STD Syndromic Management in LAC: the AIDSCAP Experience, complete with lessons learned and recommendations.

**Monitoring the AIDS Pandemic (MAP) Network. *The Status and Trends of the HIV/AIDS Epidemic in the World*. Geneva, Switzerland: MAP Network Symposium. June 26, 1998.**

This status report on the HIV/AIDS Epidemic was produced at the fifth regional and global "Status and Trends" symposia organized to expand the understanding of the trajectory and determinants of the HIV/AIDS pandemic. MAP members include professionals from around the world, working in various capacities in the HIV/AIDS field. This report complements the UNAIDS/WHO report on the global HIV pandemic released in early 1998.

Information on the status of the epidemic is presented by region with a special section devoted to India. The third part of this report focuses on migration and HIV, highlighting refugees and internally displaced persons. Part four identifies the inequities in care and support for those infected with and affected by HIV. Part five discusses the potential global impact of mother-to-child HIV transmission; transmission in the health care setting and among orphans; interactions between TB and HIV programs; and knowledge and action gaps. MAP members leave us with recommendations for future efforts with special emphasis placed on behavioral research.

**Reid, Elizabeth. "The HIV Epidemic and Development: The Unfolding of the Epidemic." *Issues Paper #1*. New York, NY: United Nations Development Programme. 1991.**

This broad overview of the HIV epidemic and its impact on societies has particular significance to developing countries. The author paints a picture of the setting in which

the epidemic unfolds; her analysis places people and their communities at the center of the exploration of the repercussions of the spread of the HIV virus. First, we get a glimpse at the factors involved in transmission: 1) inequalities of wealth, power, and autonomy; 2) attitudes toward women; 3) community norms and values; 4) pathology and immaturity of the genital area leading to injury and infection; and 5) mobility of people.

Most of the discussion contained in this issues paper highlights the fluid motion of the epidemic that has materialized over time. There are four dominant "waves of consequences" as identified by the author. She describes the "waves" in detail and also provides two figures that clearly present each stage of the epidemic. The final section examines the future challenges of the HIV epidemic.

**USAID. *Integration of Family Planning/MCH with HIV/STD Prevention. Programmatic Technical Guidance. Priority for Primary Prevention with a Focus on High Transmitters.* Washington DC: Population, Health, Nutrition Center (Office of Population, Office of Health, and Office of Field and Program Support) USAID. December 1998.**

This document reviews the latest global research and country program experience to determine the most effective integrated approaches to prevent transmission of HIV and STDs. The report identifies the common weaknesses of integrated programs that limit the impact of these approaches. The document also examines several components of integrated programs and makes recommendations for these efforts. Topics covered in the report include: priority interventions; primary prevention through condom promotion and behavior change; addressing the role of high transmitters balanced with interventions for the general population, especially men; clinical management of STDs; limitations of syndromic management of vaginal discharge; when to integrate clinical STD management interventions into an MCH/FP program; and the STD management research agenda.

***What are the Characteristics of HIV Education and Prevention Programs that "Work" and "Do Not Work."* HIV Education and Prevention Working Group Meeting, August 7, 1991, Office of AIDS, California Department of Health Services, and IHPS, UCSF. HIV E&P Evaluation, IHPS, UCSF, 1992. Office of AIDS, California Department of Health Services.**

This matrix serves as a quick reference tool for evaluators assessing an HIV Education and Prevention Program. The purpose of the tool is to assist in identifying strengths and weaknesses in program design. It may also be used as a checklist.

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## Breastfeeding

**Bender, Deborah E., Baker R., Dusch, E., and McCann, M. “Integrated Use of Qualitative and Quantitative Methods to Elicit Women’s Differential Knowledge of Breastfeeding and Lactational Amenorrhea in Periurban Bolivia.” *Journal of Health and Population in Developing Countries*. 1 (1): 68-64. 1996.**

This paper combines qualitative and quantitative methods of data collection to report findings from a larger study on infant feeding and child spacing in periurban communities in Bolivia. First, the investigators discuss the application of paradigms to data collection methods in social science research by examining current and historical trends. Next, they establish a link between their use of a focus group and a cross-sectional survey instrument for this study. The third section of this paper discusses the survey respondents knowledge of lactational amenorrhea and mother’s beliefs about use of other contraceptive methods for breastfeeding women. The final portion of this paper is a review of the authors’ methodology and a discussion about the challenges inherent in the combined use of quantitative and qualitative methods.

The survey data revealed some knowledge of the protective effects of breastfeeding among the women. However, the focus group data exposed inconsistencies in regard to understanding the amenorrheic effect of breastfeeding and women’s willingness to use a second contraceptive method to extend the protective effects of lactational amenorrhea. Furthermore, the narrative responses portrayed the women’s deeply held convictions and their frustrations that probably influence their contraceptive practice. The data collected by the authors contributed to the development of guidelines that promote the lactational amenorrhea method at the community level in maternity and family planning settings.

**Cooney, Kristin A. and Labbok, M. with Shirley Coly, Guest Editors. Breastfeeding as a Women’s Issue: A Dialogue on Health, Family Planning, Work and Feminism. *International Journal of Gynecology and Obstetrics*. vol. 47. Ireland: International Federation of Gynecology and Obstetrics. December 1994.**

On September 13, 1993, the Breastfeeding and Child Health Division of the Institute for Reproductive Health, Department of Obstetrics and Gynecology, at the Georgetown University Medical Center sponsored a policy meeting to foster a more open and direct dialogue on the issues of health, family planning, work and feminism as they relate to breastfeeding. This supplemental issue of the *International Journal of Gynecology and Obstetrics* is a collection of papers on the four major themes of the conference. The keynote address, commentary, and a conclusion that outlines a strategy for action are also included in this volume.

Participants agreed on twelve themes that surfaced during the conference. The themes fall into four categories: women and health care; women and other life choices; women and men; and women and political action. M. H. Labbok’s piece, “Breastfeeding as a Women’s Issue: Conclusions and Consensus, Complementary Concerns and Next Actions,” summarizes the issues covered during the conference with the statements that

achieved general consensus; presents complementary issues that may serve to round out conference discussion within the context of breastfeeding as a women's issue; and comments on actions remaining to be taken. Appendices include the complete program, biographical information on presenters and the participant list.

**Jansson, U.M., Mustafa, T., Khan, M.A., Linbald, B.S., and Widstrom, A-M. "The Effects of Medically-oriented Labour Ward Routines on Breastfeeding Behavior and Body Temperature in Newborn Infants." *Journal of Tropical Pediatrics*. Oxford University Press: Oxford, England. vol. 41. December 1995.**

This paper by Swedish and Pakistani researchers supports the advantages of early mother-infant contact already established in pioneering Swedish studies. Forty-eight vaginally delivered infants of a delivery ward in Islamabad, Pakistan, were observed for this study. All newborns were immediately separated from their mothers and then bathed and swaddled. The aim of the researchers was to evaluate the effects of a developing country's labor ward routine on the behavior and body temperature of a newborn during the first hour after birth.

The Pakistani practice of bathing and swaddling the newborns before initiating skin-to-skin contact with the mothers was found to interfere with the infant's inborn ability to signal hunger. In addition, forty-one of the infants (85%) were hypothermic at one hour and some did not show the normal prefeeding behaviors of hand-to-mouth and rooting movements. The researchers recommend an improvement in care, which advocates skin-to-skin contact of the newborn with its mother to keep the baby warm and facilitate early breastfeeding.

**The LINKAGES Project. *FAQ Sheet – Frequently Asked Questions on: Breastfeeding and HIV/AIDS*. Washington, DC: Academy for Educational Development. January 1998.**

This FAQ sheet is a short guide to the current international recommendations on breastfeeding and HIV and the latest information on HIV transmission via breastfeeding.

It addresses six common questions and reviews the policy and program needs for field activities. Guidelines for health workers are provided with the recommendation that health workers tailor their advice to the individual needs of each mother.

**O'Gara, Chloe, Newsome, M. H., and Viadro, C. *Indicators for Reproductive Health Program Evaluation*. Chapel Hill, NC: The EVALUATION Project. December 1995.**

The Reproductive Health Indicators Working Group (RHIWG) was established in April 1994 by the EVALUATION Project at the request of the UNITED STATES Agency for International Development (USAID). The task of the RHIWG was to develop indicators for program evaluation in areas of reproductive health. This report is a compilation of the Breastfeeding Subcommittee's work and it is a collaborative effort between field experts, the Carolina Population Center, Tulane University, and The Futures Group International. The review process included an external reviewer as well as staff from USAID. Comments from the reviewers have been incorporated into this report.

The Subcommittee on Breastfeeding has drawn up a summary list of thirty-eight indicators as well as a short list of nine primary indicators that are thought to be the most useful in monitoring interventions. In addition, this report includes five breastfeeding practices indicators recommended by the World Health Organization for tracking global trends. Chapter One is a short discussion on the background of breastfeeding, the technical challenges in evaluation breastfeeding policies and programs and the indicators used to measure breastfeeding. Chapters Two and Three are divided into output indicators and outcome indicators, respectively. Within each chapter, the evaluating indicators are grouped topically and the information provided for each indicator includes its definition, its measurement, data requirements and data sources for the indicator, the purpose of the indicator and issues related to the indicator. A proposed conceptual framework for organizing the indicators to monitor and evaluate programs designed to promote breastfeeding is presented as an appendix.

**Sanghvi, Tina and Murray, John. “Improving Child Health through Nutrition: The Nutrition Minimum Package.” Arlington, VA: Basic Support for Institutionalizing Child Survival (BASICS) Project, for the United States Agency for International Development:. 1997.**

BASICS Technical Officers selected the most important health and nutrition behaviors of caretakers in the home as they impact morbidity and mortality, and examined their feasibility, cost-effectiveness and measurability in this publication. The background section provides the technical justification for the Minimum Package and it addresses each of the six key behaviors/interventions. The next section summarizes evidence of the efficacy and effectiveness of the selected interventions, and the last section discusses measurement issues. Also included are population-level, health facility-level and program-level indicators for monitoring the Minimum Package.

Malnutrition in developing countries increases the likelihood of mortality from a number of different disease entities. Breastfeeding contributes to improved infant health by decreasing the risk of morbidity and mortality due to diarrhea, respiratory diseases and infections and contamination from other fluid sources. The Nutrition Minimum Package promotes exclusive breastfeeding for about six months and appropriate complementary feeding from about six months in addition to breastfeeding until 24 months. To obtain the best results, programs should adapt nutritional interventions to local circumstances and incorporate them into primary health care activities at the household, community, and health facility levels.

**Tolstoplatov, B., Popovic, D. and Pejcin-Stokic, L. “Cost of Infant Feeding in Former Yugoslavia.” *International Child Health: A Digest of Current Information*. vol. VII, no. 2, pp. 39-44. April 1996.**

This study was conducted as an initial attempt to estimate infant feeding costs at the national level and to assess the possible health benefits of increased breastfeeding prevalence. It focuses on family expenses related to infant feeding and costs for treatment of patients suffering from diseases for which a link between the prevalence and breastfeeding has been medically proven. The diseases examined included childhood

cancer, diabetes mellitus, ear infections, acute respiratory infections, breast cancer, and epithelial ovarian cancer. The researchers present data on the cumulative costs of baby feeding and morbidity on each of the investigated diseases.

The results indicate that the costs of artificial feeding result in significant expenses that could be minimized through increased breastfeeding. The authors estimate that families from countries in the Former Yugoslavia must spend approximately 70% of their average income on artificial feeding during an infant's first six months. They calculate savings of US\$40 million if an increase in the breastfeeding rate from 30% of partially-breastfed infants at four months to 70% is achieved.

**Wellstart International. *Armenia: The Effect of a Multifaceted Approach to Breastfeeding Promotion*. Country Case Study, no. 3. March 1998.**

In 1993, USAID sponsored a study on infant feeding practices in Armenia that revealed drastically declining breastfeeding rates. Therefore, USAID ceased all donations of formula to Armenia in 1994. The Ministry of Health anticipated a national crisis unless the breastfeeding rates were immediately increased. This country case study describes the multifaceted approach developed by the Armenian Ministry of Health to avoid the emergency situation that would have been caused by further deterioration of infant feeding and health practices.

Considerable improvements have been made in a very short period of time. According to MOH figures, the prevalence of full breastfeeding at the age of four months in 1996 was 41.7%, up from approximately 20% in 1994. Wellstart International commends Armenia's commitment to a national policy on breastfeeding and a national breastfeeding program; an intensive mass media communication campaign aimed at mothers to improve their knowledge, attitudes and practices; changes in hospital postpartum practices; and the training of perinatal health care providers in lactation management. A final section reflects on Armenia's experience and lessons learned that will guide future plans for its breastfeeding promotion program.

**Wellstart International. *The Lactation Management Education Experience, 1983-1998: Accomplishments, Lessons Learned, and Recommended Strategies*. Washington, DC: Submitted as final report for Cooperative Agreement, United States Agency for International Development. March 31, 1998.**

Since 1983, Wellstart International's Lactation Management Education (LME) Program has provided education and technical support to health professionals around the world. USAID has provided support for the LME Program through a cooperative agreement with Wellstart International. This final report document offers lessons regarding leadership development, motivation and behavior change, networking and program development, and institution building. Also presented in this report are a number of recommended strategies on faculty development and technical support, associate network development, preservice curriculum change, national program development, national/regional center development, and support for international policies, events, and initiatives. A small number of the collaborating countries and projects are highlighted and information is summarized and graphically portrayed when possible.

The core approach of the LME Program is to provide education, leadership development, and ongoing technical support to “Wellstart Associates” who are in positions of influence and able to impact the health care system. The LME Program promotes the value of field-based participation in the development and implementation of activities. Moreover, the LME Program provides assistance with planning and evaluation. Critics of the LME Program assert that the LME Program is 1) too expensive, 2) a US-based training course, and 3) the LME Program is a limited, vertical, facility-based program. Wellstart International responds to this feedback in the final summary and conclusion section.

**WHO Division of Child Health and Development. “Hepatitis B and Breastfeeding.”**  
*Division of Child Health and Development Update.* Geneva, Switzerland: WHO.  
November 1996.

This is a statement prepared jointly by the Global Programme for Vaccines and Immunization (GPV) and the Divisions of Child Health and Development (CHD), and Reproductive Health (Technical Support) (RHT) of the World Health Organization (WHO). It provides information about Hepatitis B virus and breastfeeding.

While there is no evidence that breastfeeding increases the risk of mother to child transmission, small amounts of Hepatitis B surface antigen have been detected in some breast milk samples. WHO recommends immunization of the newborn with HB vaccine if feasible, especially where perinatal transmission rates are high. When limited supplies of HB vaccine are available, priority should be given to infants who will receive breast milk from someone other than their mothers. In the event that vaccination is not possible, breastfeeding is still recommended.

**WHO Global Data Bank on Breastfeeding.** Geneva, Switzerland: WHO. 1996.

The World Health Organization (WHO) maintains an international data bank on breastfeeding as part of its regular nutrition surveillance activities. Data are collected on two types of indicators: those derived from households and those used to assess health facility practices that affect breastfeeding, which are also part of the Baby-Friendly Hospital Initiative. Information provided by the WHO Global Data Bank can be used for comparisons between countries and regions, and within countries; assessment of breastfeeding trends and practices as a basis for future action; monitoring of breastfeeding prevalence and trends, and analysis of trends over time; evaluation of the impact of breastfeeding promotion programs; and ready access to current data for use by policy-makers and decision-makers, scientists, researchers, hospital administrators, health workers, and other interested parties.

This book presents an overview of global breastfeeding practices and introduces the breastfeeding indicators used by WHO. Moreover, this introduces the Global Health Data Bank as a resource. Because WHO is committed to preparing a report every two to three years on breastfeeding trends in all countries for which data are available, this tool is an especially useful background document for evaluation teams.

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## Additional Resources on Nutrition

Becktell, Phoebe J. "Endemic Stress: Environmental Determinants of Women's Health in India." *Health Care for Women International*. 15:111-122. Taylor & Francis. 1994.

Galloway, Rae and Cohn, A. eds. *Indicators for Reproductive Health Program Evaluation: Final Report of the Subcommittee on Women's Nutrition*. Chapel Hill, NC: The EVALUATION Project, Carolina Population Center. December 1995.

Loaiza, Edilberto. *Maternal Nutritional Status. DHS Comparative Studies*, no. 24. Calverton, MD: Macro International. 1997.

"Micronutrients for the Health of Women and Newborns." *MotherCare Matters*. vol. 6, no.1. Arlington, VA: John Snow, Inc. November/December 1996.

"On the Pathway to Maternal Health—Results from Indonesia." *MotherCare Matters*. vol. 5, no. . Arlington, VA: John Snow, Inc. February/March 1995.

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# **Annotated Bibliography On Financial Sustainability**

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## Financial Sustainability

**Barnett, Barbara. "Do Client Fees Help or Hurt?" *Network*: vol.18, no.2. Research Triangle Park, NC: Family Health International. 1998.**

This short, topical paper addresses three issues for family planning program managers to address before implementing a client fee system for contraceptives and services. First, the availability of family planning for everyone must be assessed. Next, program managers must determine how much things cost, including administrative, staffing, and supply costs. Finally, pricing contraceptives and services for sustainability of programs will depend on whether the program manager's goal is to achieve institutional sustainability or contribute to the sustainability of the national family planning program. The author has conducted a comprehensive literature review and synthesized research findings from a broad panel of field experts.

**Day, Laurence M. *Designing a Family Planning User Fee System: A Handbook for Program Managers*. Arlington, Virginia: John Snow, Inc. Family Planning Service Expansion and Technical Support (SEATS) Project. 1993 (Revised Edition).**

This booklet presents 10 steps for designing or redesigning a family planning user fee system. Each of the ten steps are accompanied by a brief introduction which offers an overview of the main considerations involved in that step, one or more worksheets to help with some of the specific design tasks, and end notes which comment on certain elements in the worksheets. This hands-on tool is appropriate for program manager use at the local, regional, or national level. If a user fee system is already in place, this is a practical guide for conducting a review of existing components. Additionally, program managers may consult this guide for information that will assist them in determining whether a user fee system is appropriate and sustainable. A glossary is included in the appendices and a companion booklet, Background Discussion for the Handbook for Program Managers, provides further discussion of issues pertaining to family planning user fees.

**Foreit, Karen G. and Levine, R. E., *Cost Recovery and User Fees in Family Planning*. Policy Paper Series, no. 5. Washington, DC: The Futures Group and The Urban Institute. September 1993.**

The growth in demand for family planning services, coupled with constrained financial resources in the public sector, has left many national family planning programs tapped out. As a result, some governments have adapted user fees to lessen the burden on family planning service providers. This paper focuses on initiating cost recovery efforts and/or rationalizing the existing fees charged to individual users of services provided by subsidized family planning outlets. The authors present a strategy for initiating or increasing user fees outlining the major steps that need to occur in a family planning program for user fees to be viable. Governments provide free family planning services to

promote higher contraceptive prevalence rates and to ensure access to the poor; however, untargeted free or low-cost health subsidies tend to provide greater access to services in urban, relatively well-off areas, at the expense of the poor and rural populations. This overview discusses problems with universal free services and examines the advantages of user fees. In general, funds must be kept and used at the operational level where they are collected; otherwise, service providers and administrators will have little incentive to collect them.

**Janowitz, Barbara and Bratt, J. H., *Methods for Costing Family Planning Services*. United Nations Population Fund and Family Health International. 1994.**

Professionals who will organize and conduct costing analyses of family planning programs are the primary audience for this manual. The authors' central purpose is to provide guidance on how to apply costing techniques to each service delivery channel within a family planning program. Their "bottom-up" approach to costing begins with listing all of the services that should be costed. Next, all of the resources that are used to produce each service are identified; finally, the total cost of each service is then calculated by adding up the individual costs of all resources used. Chapter One discusses the uses of cost analysis. Chapter Two outlines a conceptual framework for thinking about family planning programs as production units, in which inputs are used to produce family planning services. Chapter Three reviews the fundamentals of cost analysis, focusing especially on definitions of various types of costs and ways to classify costs. Chapter Four provides guidance on the mechanics of gathering cost data, and Chapters Five and Six explain how to allocate costs to family planning services in clinical and non-clinical delivery systems. Chapter Seven relates costs to outputs and Chapter Eight presents some examples in which information on costs is used to make resource allocation decisions.

**Levine, Ruth E. and Bennet, J. *Sustainability of Family Planning Programs and Organizations: Meeting Tomorrow's Challenges*. Policy Paper Series, no. 6. Washington, DC: The World Bank and The Futures Group International. January 1995.**

This paper examines the elements of both a sustainable national family planning program and an important component of that program, a sustainable private voluntary organization (PVO). The authors' introduction reviews programmatic sustainability, focusing on the government's role in the public sector, and organizational sustainability. The following chapter focuses on the role of donors and policy options to promote sustainability, including guidelines for designing projects for programmatic and organizational sustainability. A matrix summarizes the determinants of sustainability at the program and organizational levels, the policy options that governments and organizations can pursue, and the role of donors in supporting policy change and implementation. Three country case studies (Thailand, Indonesia, and Colombia) illustrate the ways in which well-run public sector service delivery and public/private partnerships can strengthen the financial and institutional autonomy of a family planning program.

**Shaw, R. Paul and Griffin, C., *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance*. Washington, DC: The World Bank. 1995.**

This book concentrates on two methods of cost recovery: user fees and self-financing insurance. In the introduction, the authors' share lessons learned based on their experience with these strategies in sub-Saharan Africa. Comprehensive discussions of each strategy with charts and tables are found throughout the text. Chapter One concentrates on user fees in public health facilities and the substantial positive impact these charges can have on the efficiency, equity, and sustainability of health financing in Africa. Chapter Two begins with an overview of the principles and practice of self-financing health insurance, drawing on the limited but growing experience of some African countries. The evolution of risk-sharing mechanisms and the principals of insurance are described briefly and obstacles to setting up health insurance programs in Africa are discussed. An appendix table rates the feasibility of insurance systems in African countries and is followed by a very extensive reference list.

**Leighton, Charlotte, et. al. "Twenty-Two Policy Questions About Health Care Financing in Africa." *The Health and Human Resources Analysis for Africa (HHRAA) Project of the USAID Africa Bureau*. 1995 edition.**

This issues brief is part of a larger series; financial sustainability is one of five topics covered. Each topic is intended to be a brief, non-technical reference on the "state-of-the-art" for senior decision-makers, program planners, and facility managers. For readers who want more detail, each topic closes with an alphabetical list of references. Each topic begins with an overview of the theme covered, highlighting the relevance and context of the policy issue(s) addressed. The topic is then divided into questions. Five questions are covered under financial sustainability:

- Are people willing to pay for health services?
- Can people afford to pay for health services?
- Can cost recovery initiatives raise enough revenue to make a difference for financial sustainability in countries where most people are poor?
- What is the impact of cost recovery on financial sustainability at primary care facilities and hospitals?
- What else could be done to tap potential sources of finance for public health facilities?

**Partnerships for Health Reform. *Measuring Health System Performance: A Handbook of Indicators*. Bethesda, Maryland: Abt Associates. September 1997.**

This handbook presents indicators for the five key dimensions of health system performance: access, equity, quality, efficiency, and sustainability. Through definitions and discussion of each of these elements, and then presentation and explanation of the indicators themselves, the handbook attempts to make the indicators understandable, accessible and usable. Health system performance indicators are used to measure the

results of health care reform in low and middle income countries. The handbook indicates that approaches to health reform may vary widely from country to country, system to system. It is intended to enable local health professionals and donor organizations to design and implement, and then evaluate and refine the health sector based on empirical evidence to achieve desired reforms; and to compare reform results within levels of a system and internationally. Finally, the handbook presents a methodology to select the most relevant indicators.

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# **Annotated Bibliography on Quality and Access**

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## Quality and Access

**Bongaarts, J. and Bruce, J. “The Causes of Unmet Need for Contraception and the Social Content of Services.” *Studies in Family Planning*. vol. 26, no. 2. New York: The Population Council. March/April 1995.**

Bongaarts and Bruce begin their review of unmet need for contraception by defining unmet need and explaining how it is measured. Unmet need is not directly measured but is derived from women’s desired fertility and current contraceptive use or non-use. The authors have included estimates of unmet need for sub-Saharan Africa, Latin America, Asia, and the North Africa/Middle East region. The central thesis of the article is that unmet need is more than an issue of access, but is related to other equally important issues such as the side effects of contraception and societal and familial disapproval of contraceptive use. Access, as measured by proxies for service availability, is not as crucial to contraceptive use as knowledge about contraceptives, health and safety concerns, and husbands’ objections. The authors emphasize the need to move beyond the provision of services to address cultural and gender issues through IEC programs, especially for vulnerable populations such as adolescents.

**Bruce, Judith. *Fundamental Elements of the Quality of Care: A Simple Framework*. New York: The Population Council. May 1989.**

In this critical piece on the quality of care in family planning programs, Judith Bruce describes the rationale for developing standards of quality for programs, outlines a framework for quality of care that includes six fundamental elements and discusses possible applications of the framework in practical settings. Bruce introduces the concept of quality of care as it relates to family planning programs in low-resource settings and presents arguments to defend the study of quality of care. She details the history of quality of care initiatives, which have generally centered around clinical issues. Though this publication is not recent, it provided the foundation for the past ten years of initiatives in quality of care, and for that reason, this piece is key to understanding recent trends.

Bruce’s framework consists of the following elements: choice of methods presented to users, information given to users, technical competence, interpersonal relations between clinic staff and users, follow-up and continuity mechanisms, and an appropriate constellation of services provided to users. After fully describing each element, she reviews case studies including quantitative and qualitative research that demonstrate their impact on user satisfaction and improved quality of family planning programs. Bruce concludes her article with a section on the practical application of the framework for evaluation of programs.

**Dwyer, Joseph and Jezowski, T. *Quality Management for Family Planning Services: Practical Experience from Africa*. AVSC Working Paper, no. 7. New York: AVSC International. February 1995.**

This document, part of the AVSC Working Paper Series, provides an overview of the practical aspects of quality management of family planning programs based on AVSC International's experiences implementing quality management in selected locations in Africa. The sites in Africa were chosen as case studies because of the need to test the application of such ideas in low-resource, infrastructure-deficient settings. After establishing a link between the operations of family planning programs and contraceptive prevalence, the authors identify obstacles to the use of services. They present solutions to identify and resolve problems of quality management by using an AVSC self-assessment tool known as COPE (Client Oriented, Provider Efficient). Applications of the tool are reviewed and the authors conclude with suggestions for the future of quality management based on the results from the examples in Africa.

**Huezo, Carlos and Diaz, S. "Quality of Care: Client's Rights, Provider's Needs." *Advances in Contraception*. vol. 9. 1993.**

Huezo and Diaz outline the rights of clients and the needs of providers as studied by the International Planned Parenthood Federation, with suggestions and examples of how to integrate these concepts into service delivery programs. The ten rights of clients include the rights to information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity, and opinion. The authors define each right and provide examples of how providers should observe them in a care-giving setting. They focus on provider attitudes and suggest that providers think through their personal experiences with women to understand what affects their interaction with clients and how they can improve such relations.

The second half of the article discusses providers' needs and suggests a general strategy for developing a service delivery system that links them with clients' rights. These needs are: training, information, infrastructure, supplies, guidance, back-up, respect, encouragement, feedback, and self-expression. The authors caution against reactive strategies and suggest program structures that are oriented toward prevention of problems for both clients and providers, fully encompassing the human aspects of quality of care.

**Jain, Anrudh. *Managing Quality of Care in Population Programs*. West Hartford, CT: Kumarian Press, Inc. 1992.**

This collection of eight articles reviews quality of care issues from two different perspectives. The book is divided into two sections: "Managing and Improving Quality of Care" and "Measuring and Monitoring Quality of Care." Following an introductory chapter is a description of Judith Bruce's framework for the organization of quality of care issues. The first section consists of three essays that discuss management theories as they relate to quality of care in family planning programs. For example, in Chapter Three, Bruce argues that management of family planning programs should fully take into

account a women's perspective on services; not just a reproductive health perspective, but a view that includes the daily reality of the women served by the program.

Part Two consists of three chapters on monitoring quality of care at different levels: policy, service delivery points, and clients. The articles describe but do not suggest indicators for quality at each level. Jain concludes by recognizing that these indicators are crucial to the improvement of quality of care, and it should be noted that the recent EVALUATION project took on the development of these indicators at the same time that this book was published.

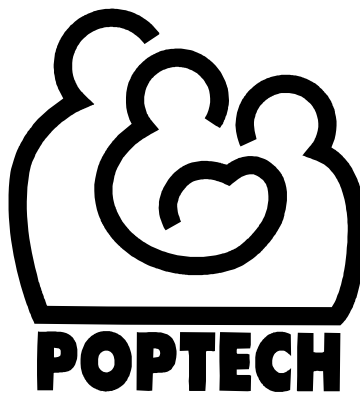
**Mensch, B., Arends-Kuenning, M., and Jain, A. "The Impact of the Quality of Family Planning Services on Contraceptive Use in Peru." *Studies in Family Planning*. vol. 27, no. 2. New York: The Population Council. March/April 1996.**

This case study begins with a review of the demand versus supply side debate on the effect of family planning on fertility decline. The authors describe problems associated with measuring influences on individual fertility behavior, noting that most research has focused on access to and availability of contraceptives as they influence use. It is only recently that researchers in this field have begun to look at quality of care as an influence on individual behavior. The article continues with a detailed description of the methodology used to conduct the research, which involves a combination of situation analysis and analysis of DHS data. This case study of Peru was the first to link these two types of data for the purpose of looking at quality of care. Overall, the authors find that quality of care is positively related to contraceptive use despite the number of caveats explaining biases due to methodology, data, and Peruvian policy regarding quality of care. The appendix lists and defines the quality of care variables used to analyze the behavioral effects.

**Shelton, James D., Davis, S., and Mathis, J. *Maximizing Access and Quality: Checklist for Family Planning Service Delivery, With Selected Linkages to Reproductive Health*. Baltimore, MD: Johns Hopkins University Population Information Program. 1998.**

This publication, also known as the MAQ Checklist, promotes access to quality services; client orientation; support for quality and access from the top levels of family planning services delivery management; building quality and access from the "bottom up"; and built-in approaches to evaluate and improve services. It is divided into five sections: Service Delivery, Access, Potential Barriers to Quality Service, Support of Services, and Service Frameworks. Each section is further broken down into categories of questions, with priority questions in each category printed in bold.

For example, the items related to Service Delivery are grouped under the subheadings of Client-Provider Interaction; Technical Competence; Infrastructure, Physical Facilities and Equipment; Methods/Commodities; Privacy and Confidentiality; and Infection Prevention. The checklist includes references to other resources that provide information on these individual issues.



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